(b) The rate developed from the initial budget report shall be subject to all the requirements of Section (c)(3) and (4) and shall be effective for the remainder of the then current rate period.

(xvi) The cost of principal and interest payments on mortgage loans from the New York State Facilities Development Corporation (hereinafter referred to as FDC) pursuant to subdivision 13-d of section 5 of the New York State Facilities Development Corporation Act, net of the portion of payments attributable to operating costs, shall be allowable, provided that the reimbursement of such costs is an allowance in lieu of reimbursement of interest and depreciation associated with the mortgaged property and in lieu of reimbursement for the underlying allowable costs, which may include allowable start-up costs, for which the FDC mortgage loan was received. A provider which receives an FDC mortgage loan, pursuant to subdivision 13-d of section 5 of the New York State Facilities Development Corporation Act does not have the option of having included in the calculation of its rate otherwise allowable interest, depreciation or the loan's underlying costs instead of the allowance representing principal and interest.

(xvii) Liability for compensated absences determined and accrued in accordance with generally accepted accounting principles for governments as promulgated by the Governmental Accounting Standards Board shall be considered an allowable cost.

(xviii) Advance refunding costs incurred in connection with the refunding of bonds, and determined in accordance with generally accepted accounting principles, shall be considered allowable cost.

(11) All interim rates, base period rates, subsequent period rates, and any adjustments to a facility's rates shall not be considered final, unless approved by the director of the Division of the Budget.

(12) Funded Depreciation

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(i) Applicability. §(c)(12) shall apply to all facilities except those governed by §(c)(10)(x)(d) or (e) and those for which the provider is receiving or has a commitment to receive HUD funding. This Section shall apply to facilities which were governed by §(c)(10)(x)(d) or (e), but which are no longer governed by either such Section because the provider has repaid the entire principal owed on the real property of the facility.

(ii) Effective April 1, 1986, for any rate period during which the reimbursement attributable to depreciation on a facility's real property, excluding equipment, exceeds the provider's principal repayment obligations on indebtedness attributable to such real property, such provider shall fund depreciation by depositing such difference in an interest-bearing checking account or other secure investment. If the provider operates more than one facility governed by this §(c)(12), the provider may maintain one funded depreciation account for two or more facilities. The provider shall not commingle such funded depreciation account(s) with other monies of the provider. The provider shall not be required to fund depreciation attributable to the provider's equity in such real property. The provider may expend the funds in such account, including accrued interest, to retire all or a portion of the indebtedness attributable to such real property, or for building improvements and/or fixed equipment necessary to the facility.

(d) Appeals of Rates

(1) First Level Rate Appeals

[(1)](i) The Commissioner will consider only the following appeals for adjustment to the rates which would result in an annual increase of $1,000.00 or more in a facility's allowable costs, and are:

[(i)] (a) Needed because of changes in the statistical information used to calculate a facility's staffing or utilization standards; or

[(ii)] (b) Requests for relief from the standards contained in §(c)(3)(ii)(a), (c)(3)(vii), (c)(4)(iv), (c)(7) or (c)(8), which were applied to costs used in calculating the base period and subsequent period rates.

[(iii)](c) Appeals for adjustments needed because of material errors in the information submitted by the provider which CMHDD used to establish the rate or material errors in the rate computation.

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[(iv)] (d) Appeals for significant increases or decreases in a facility's overall operating costs subsequent to the base period due to implementation of new programs, changes in staff or service, changes in the characteristics or number of clients, changes in a lease agreement so as not to involve an affiliate, capital renovations, expansions or replacements, which have been either mandated or approved by the Commissioner and, except in life threatening situations, approved in advance by the appropriate State agencies.

TN 91-56 Date JUN 25 1992
Supersedes TN 88-12 Effective Date JUL 01 1991

(ii) Effective January 1, 1988, OMRDD will no longer accept applications for new appeals to non-State operated facilities' rates effective prior to April 1, 1985. New appeal applications to State operated facilities' rates in effect prior to April 1, 1985 will not be accepted after March 31, 1988.

[(2)](iii) Notification of First Level Appeal

[(i)](a) In order to appeal a rate in accordance with section (d)(1)(ii)(iii) and (iv), the provider must send to OMRDD an appeal application by certified mail, return receipt requested, either within 90 days of the provider receiving the rate computation, or within 90 days of the beginning of the rate period in question, whichever is later.

[(ii)](b) In order to appeal a rate in accordance with section (d)(1)(i) and (d)(1)[(iv)](v), the provider must send to OMRDD within one year of the close of the rate period in question, [an] a first level appeal application by certified mail, return receipt requested.

[(3)](iv) First level rate appeal applications shall be made in writing to the commissioner.

[(i)](a) The application, shall set forth the basis for the appeal and the issues of fact. Appropriate documentation shall accompany the application and OMRDD may request such additional documentation as it deems necessary.

[(ii)](b) Actions on first level rate appeal applications will be processed without unjustifiable delay.

[(4)](v) The burden of proof on the first level appeal shall be on the provider to present clear and convincing evidence to demonstrate that the rate requested in the appeal is necessary to ensure efficient and economical operation.

[(5)](vi) A revised rate by OMRDD shall not be considered final pursuant to an appeal unless and until the appeal is granted by OMRDD and approved by the State Division of the Budget.

[(6)](vii) [There shall be a formal notification of the final decision on the provider's rate appeal. However, a] At no point in the first level appeal process shall the provider have a right to any form of interim report or determination made by OMRDD or Division of the Budget.

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At the conclusion of the first level appeal process, OMRDD shall notify the ICF/DD of any proposed revised rate or denial of same. OMRDD shall inform the facility that the facility may either accept the proposed revised rate or request a second level appeal in accordance with Title 14 NYCRR section 602.9 in the event that the proposed revised rate fails to grant some or all of the relief requested. Except as provided in item (ix) below, at the conclusion of the first level appeal process, OMRDD shall notify the ICF/DD of any proposed revised rate or denial of same. OMRDD shall inform the facility that the facility may either accept the proposed revised rate or request a second level appeal in accordance with Title 14 NYCRR section 602.9 in the event that the proposed revised rate fails to grant some or all of the relief requested.

[(7)](viii) Any rate revised in accordance with this section shall be effective according to the dates indicated in the approval of rate appeal notification. Such formal notification shall be sent to the provider by certified mail, return receipt requested.

[(8)](ix) If OMRDD approves the revision to the rate and State Division of the Budget denies the revision, the provider shall have no further right to administrative review pursuant to this section.

[(9)](x) The revision of the rate due to the appeal or the OMRDD denial of the appeal shall be final unless within 30 days of receipt of notification, the facility requests a hearing by certified mail, return receipt requested. The request must include a statement of the factual issues involved and documentation of the facility's position as to each identified issue of fact.

(2) Second level rate appeals

(i) OMRDD's denial of the first level appeal of any or all of the relief requested in the appeals provided for this section shall be final unless the facility requests a second level appeal to the commissioner in writing within 30 days of service of notification of denial or proposed revised rate.

(ii) Second level appeals shall be brought and determined in accordance with the applicable provision of Part 602 of Title 14 NYCRR.

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[(i) If the Commissioner determines there is no hearable factual issue, the Commissioner shall deny the request for a hearing and notify the facility of such denial.]

[(ii) If the Commissioner determines that there is a hearable, factual issue or that there are hearable, factual issues, the commissioner shall appoint a hearing officer and shall issue to the parties a notice of hearing setting forth the date, time and place of the hearing and the hearable, factual issue(s) in dispute.]

[(10) The facility may also submit to the hearing officer memoranda on legal issues which it deems relevant to the appeal.

(11) A hearing pursuant to this Section shall be held before the hearing officer, at which the facility shall have the burden of going forward with the evidence.

(i) At such hearing, the facility and OMRDD shall have the right to present the testimony of witnesses, arguments in support of their position and written material to substantiate their position.

(ii) Unless otherwise agreed to by the parties, the issues at the hearing shall be limited to those grounds of appeal, and those items of expense which the OMRDD denied.

(iii) Any documents prepared by OMRDD or the New York State Department of Social Services' fiscal agents shall be presumed, in the absence of evidence to the contrary, to constitute an accurate reflection of OMRDD's records as to the amount and type of payment made to a facility as well as the basis for such payment.

(12) The hearing officer's recommendation will be submitted to the Commissioner for his decision.]

[(13)](3) Any rate revised in accordance with §(d) shall be effective according to the dates indicated in the approval of rate appeal notification.

[(14)](4) Any additional reimbursement received by the provider, pursuant to a rate revised in accordance with §(d), shall be used or allocated for reimbursement of costs relating to the specific issues determined in favor of the provider.

(e) Audits

(1) Each provider shall maintain the statistical and financial records which formed the basis of the reports submitted to the Commissioner for six years from the date on which the reports were submitted or due whichever is later, or for such longer period as may be required under Federal law.

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(2) All such records shall be subject to audit for a period of six years from the later of the date on which all required reports were filed with the Commissioner or the date on which such reports were due.

(i) Field audits or desk audits shall be conducted by the Commissioner or the Department of Social Services at a time and place and in a manner to be determined by the Commissioner or the DSS.

(ii) The audits may be performed on any financial or statistical records required to be maintained.

(iii) Any finding of an above described audit shall constitute grounds for recoupment at the discretion of the commissioner, provided that such audit finding relates to the questioned costs, and, where applicable, to the extent that, except as authorized Subpart iv below, the audit finding has been upheld in a decision after a hearing.

(iv) If a request for hearing shall have been timely made and the Office of Administrative Hearings is unable to schedule the hearing so that it is commenced within 90 days of receipt of such request or if the department is unable to proceed within 90 days, any recovery begun under this section shall be stayed pending the commencement of the hearing. If a hearing shall have been scheduled to commence within 90 days of receipt of a hearing request, any delays or adjournments of the commencement of the hearing occasioned by or attributable to the provider, his attorney or authorized representative shall not forestall the commencement or continuation of recoupment. However, any delays or adjournments occasioned by or attributable to the department shall forestall the commencement or continuation of recoupment.

(3) All administrative review (including hearings) of audits conducted to determine allowable Medicaid expenses and offsetting revenues shall be subject to Department of Social Services guidelines and procedures on conducting hearings and administrative reviews of audits as described in 18 NYCRR Part 517.

(4) All administrative review of audits which are conducted by OMRDD, and which are not described in §(e)(3) above, shall be in accordance with §(e)(4).

(i) At the conclusion of the audit, the provider shall be afforded an opportunity to submit additional documentation to the Commissioner. After the receipt and review of such additional documentation, a copy of the audit findings shall, within 120 days, be sent to the provider by certified mail, return receipt requested. In order to have the additional documentation considered, the provider must submit the documentation within the time specified.

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(ii) The audit findings shall become final unless, within thirty days of receipt thereof, the provider requests an administrative review of the audit findings.

(iii) Request for administrative review of audit findings shall be sent to the Commissioner by registered or certified mail, return receipt requested.

(iv) The provider shall be notified in writing of the determination of those items to which the provider objected, including a statement of the reasons thereof. The audit findings, as adjusted in accordance with the determination after administrative review, shall be final.

(v) Such requests shall contain a detailed statement of the provider's objections to the findings, along with copies of any documentation the provider wishes to submit.

[(f)][Exercise of Commissioner's Discretion]

[(1)] [The Commissioner may exercise discretion in the following instances including but not limited to:]

[(i)] [Specification of budget or cost report submittal requests and period dates (§(a)(1)(i)(b) and (ii)(b)).]

[(ii)] [Relevancy of requests for statistical information (§(a)(2)(ii)).]

[(iii)] [Principles governing completion of financial reports (§(a)(3)(i) and (a)(4)(v)).]

[(iv)] [Extensions of deadlines for delivery of required reports (§(a)(4)(i) and (ii)).]

[(v)] [Imposition of financial penalties for failure to report (§(a)(4)(iii)).]

[(vi)] [Cancellation of financial penalties ((a)(4)(iv)).]

[(vii)] [Allowance of start-up costs (§(c)(5)(i)).]

[(viii)] [Programmatic changes affecting rates of reimbursement (§(d)(1)(iv).]

[(ix)] [Allowability of costs (§(c)(10)).]

[(x]) [§(c)(10)(ix)(a) and (j)).]

[(xi)] [Decisions on Rate Appeals (§(d)(1)(i), (ii), (iii) and (iv).]

[(xii)] [Application to change cost reporting year end (§(a)(1)(ii)(e)).]

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(f) Screen Values

(1) The following cost category standards are the maximum reimbursable costs which will be utilized to screen non-State operated under 31 bed provider costs.

(i) Administrative Screens

Bed Range	Region 1		Region 2		Region 3	
1 - 5	[$ 41,985]	$ 41,170	[$ 44,019]	$ 43,164	[$ 45,711]	$ 44,824
6 - 9	[69,629]	68,277	[65,125]	63,860	[63,633]	62,398
10 - 14	[96,781]	94,902	[89,295]	87,561	[86,798]	85,113
15 - 19	[137,106]	134,444	[126,503]	124,046	[123,441]	120,064
20 - 24	[177,432]	173,987	[163,707]	160,528	[158,454]	155,377
25 - 30	[221,789]	217,482	[204,634]	200,661	[198,067]	194,221

NOTE: The above values are derived from 1986 cost report data and contain a [3%] 1% corridor. They are untrended. They are based upon a median of the array of actual salaries and site OTPS costs.

(ii) Clinical and Direct Care/Support Regional Salaries

REGION	DIRECT CARE/SUPPORT	CLINICAL
1	$15,730	$25,846
2	$16,501	$22,895
3	$16,523	$24,495

NOTE: For Region I and II the above values are derived from 1986 cost report data and contain a five percent corridor. For Region III the values are derived from 1984 cost report data reflecting a one percent increase from the previous cost category standard amount and a five percent corridor. All values are based upon the median of the array of actual salaries and are untrended. For Regions I and II the Direct Care/Support salaries are also adjusted for salary enhancement.

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(iii) Support OTPS (Other than Personal Service) Screen Values

RESIDENCE		REGION		
CAPACITY	1		2	3
[1]	[$12,583]		[$22,352]	[$ 7,646]
[2]	[17,926]		[26,711]	[13,152]
[3]	[23,270]		[31,070]	[18,829]
4	[28,613]	33,434	35,428	24,505
5	[33,957]	39,068	39,787	30,181
6	[39,300]	44,703	44,145	35,858
7	[44,643]	50,337	48,504	41,534
8	[49,987]	55,971	52,862	47,210
9	[55,330]	61,606	57,221	52,886
10	[60,674]	67,240	61,579	58,563
11	[66,017]	72,874	65,938	64,239
12	[71,361]	78,509	70,296	69,915
13	[76,704]	84,143	74,655	75,592
14	[82,048]	89,777	79,014	81,268
15	[87,391]	95,411	83,372	86,944
16	[92,734]	101,046	87,731	92,621
17	[98,078]	106,680	92,089	98,297
18	[103,421]	112,314	96,448	103,973
19	[108,765]	117,949	100,806	109,649
20	[114,108]	123,583	105,165	115,326
21	[119,452]	129,217	109,523	121,002
22	[124,795]	134,852	113,882	126,678
23	[130,139]	140,486	118,241	132,355
24	[135,482]	146,120	122,599	138,031
25	[140,826]	151,754	126,958	143,707
26	[146,169]	157,389	131,316	149,384
27	[151,512]	163,023	135,675	155,060
28	[156,856]	168,657	140,033	160,736
29	[162,199]	174,292	144,392	166,412
30	[167,543]	179,926	148,750	172,089

Note: The above values are derived from [1984 cost report data for Region I and] 1986 cost report data [for Regions II and III,] and contain a 5% [upward adjustment] corridor. They are untrended. They are based upon the regression analysis of actual costs against bed size.

(2) The following cost category standards are the maximum reimbursable costs which will be utilized to screen all State operated under 31 bed provider costs.